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State to review canceled health insurance policies

The action, which affects thousands of Californians, is the boldest yet in dealing with companies' practice of rescinding coverage of sick policyholders.

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Thousands of people whose policies were canceled by California health insurers will have a chance to win back their coverage and be reimbursed for outstanding medical bills, the Schwarzenegger administration announced Thursday.

The state's action is the boldest yet in dealing with the industry's increasingly controversial practice of canceling individual coverage -- known as rescission -- after patients have taken ill and submitted medical bills.

Cindy Ehnes, the director of the Department of Managed Health Care, said she would reopen policies dropped over the last four years by the state's five major insurers and submit them for reconsideration to an independent arbiter.

Those determined to have been wrongly canceled would be reinstated, and the insurers would be responsible for medical bills incurred while patients were without coverage, she said.

"Rescission is a harsh practice," Ehnes said. "It strips people of coverage and causes them to be uninsurable at the very time they need it most. For the first time, we are giving people a second chance to get that health coverage. We are putting our full regulatory and enforcement action to work on this. We are opening the door to health coverage for those thousands of Californians who have been impacted over the last four years."

Ehnes' department, Insurance Commissioner Steve Poizner, Los Angeles City Atty. Rocky Delgadillo, lawmakers and the courts are all scrutinizing the practice.

Those efforts gained steam in February when the first judgment in a rescission case awarded $9 million to a breast cancer patient whose coverage was canceled during chemotherapy. Health Net Inc., the insurer in that case, and Kaiser Permanente have voluntarily stopped canceling patients while awaiting guidance from authorities.

An industry spokesman said insurers have been making changes in an effort to restore confidence in the affected individual market, where consumers without access to employer-based or other group coverage can buy their own policies.

Christopher Ohman, president of the California Assn. of Health Plans, said, "On their own, health plans have been implementing new policies to strengthen and make more transparent the process for rescinding policies."

Companies are developing their own third-party reviews to validate rescissions, and they have simplified and clarified application processes and enhanced staff training, he said.

Insurers defend rescissions as a rare but important check on fraud that helps keep a lid on premiums. But critics say rescission often catches innocent consumers. They say confusing applications trap people into making honest mistakes about their medical histories.

Companies are accused of issuing coverage without verifying the information and collecting premiums until they receive claims for significant medical care. Only then, critics say, do they scrutinize the applications and pull medical records, looking for discrepancies and omissions to use as a basis for rescission.

Also Thursday, Ehnes said she would order three of the state's largest insurers -- Anthem Blue Cross, Kaiser Permanente and Blue Shield -- to immediately reinstate 26 patients whose cancellations were in her view clearly out of bounds.

Rescissions by those companies, along with those by PacifiCare and Health Net, will be subject to the independent reviews announced by the state.

Gov. Arnold Schwarzenegger hailed the move, calling it "outrageous that innocent patients have to live in fear of losing their healthcare coverage."

"I look forward to working with my partners in the Legislature to ensure this egregious practice is stopped," he said.

Ehnes launched investigations of rescissions by the state's top five insurers more than a year ago in the wake of articles in The Times highlighting the consequences of the sudden loss of coverage, including patients delaying and going without healthcare and running up medical debt.

Four of the reviews are pending. The probe of Anthem Blue Cross, believed to be the largest player in the individual market, was concluded last year. It found that all 90 sampled rescissions were flawed. Ehnes said she would fine the company $1 million but has yet to collect.

Ehnes had come under fire from lawmakers and consumer advocates in recent weeks over her attempts to negotiate resolutions with the five insurers and for failing to reinstate many patients.

She said Thursday that she had hoped to reach agreements with the insurers that would result in reinstatements for patients and broad reforms without getting tied up in legal battles. But she said she resorted to using her enforcement powers when those efforts failed. She said she expected that some of the plans might choose to fight her.

Ehnes also said she moved as quickly as she could after the state Supreme Court last month let stand a key appellate court ruling that helped define the limited circumstances under which health insurers could cancel individual and family policies.

"I try very hard to do things that ultimately hold up in a court of law, not just a court of public opinion," she said. "I don't move easily until I feel I have that defensible position. I feel I am in that position. We will vigorously defend any action that is taken, and feel like we will be sustained."

The insurers had varied responses.

Shannon Troughton, a spokeswoman for WellPoint Inc., parent company of Anthem Blue Cross, said the insurer had taken steps to improve its rescission processes before the department had concluded its investigation. "We are committed to rigor and being thoughtful in any case where rescission review is warranted," she said.

Anthem Blue Cross, the state's largest for-profit health insurer, rescinds about 1,500 policies a

year in California.

Troughton noted that the department ordered reinstatement Thursday in only eight of 90 rescissions it reviewed in its audit. But Ehnes said the 82 others and thousands of other Blue Cross rescissions awaited further scrutiny by the arbiter she appoints.

Kaiser Senior Vice President Jerry Fleming said the health plan was "supportive of an independent, third-party review process for rescission that applies fair and clear standards to assess the accuracy of the information provided by an applicant to the plan and the appropriateness of the plan's decision."

Health Net spokeswoman Margita Thompson said the company would work with the department to "meet our shared goal of ensuring people have confidence in their healthcare coverage."

Thompson said the company could not say how it would respond to the department's orders until it had time to review the details.

A Blue Shield representative declined to comment, saying the company had not had time to review the orders.

On Thursday, consumer advocates praised the spirit of Ehnes' announcement. But they cautioned that its success depended upon the credibility and independence of the arbiter she selected, the rigor of the process and the standards to which cancellations were held.

"This is wonderful and welcome news," said William Shernoff, a Claremont lawyer who represents rescinded policyholders.

Jerry Flanagan, a patient advocate with Santa Monica-based Consumer Watchdog, said, "This is an incredibly important victory. . . . a landmark step on the road to justice for the thousands of innocent patients whose health insurance was retroactively canceled."

At a news conference in Sacramento, Ehnes said the third-party review of cancellations would begin "within the month" and insurers would pay the cost of the effort, which she said would be "several million" dollars.

The state doesn't know how many policies were canceled over the four years but believes "it's thousands," she said.

Asked whether any criminal laws were violated, Ehnes said her office was in contact with the California attorney general's office. "We have spoken to them about this issue," she said, declining to elaborate.

Atty. Gen. Jerry Brown said his office had been looking into health-plan practices "for quite some time," focusing on questions of "denial of care, denial of claims and specialty care."

The goal, he said, was "to make sure that we protect policyholders and when there is an improper denial, we rectify that and we get these companies to be responsible."

He said he planned to use meetings with insurers, lawsuits or "whatever we have to do to get the job done."

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